**BlueOptions**

# Schedule of Benefits

# Plan 3559

You should carefully review this Schedule of Benefits, which is part of your Benefit Booklet, to be aware of important information concerning your share of the expenses for Covered Services you receive. Your share of the expenses, including any applicable Copayments, Deductibles, and Coinsurance responsibilities, **will vary** depending upon the Provider you choose and the setting in which the Services are rendered. References to Calendar Year Deductible are abbreviated as "CYD".

## A. Deductible and Coinsurance Amounts

| Benefit Description | In-Network | Out-of-Network |
|---|---|---|
| Individual Calendar Year Deductible (CYD) | $500 | $750 |
| Family Calendar Year Deductible (CYD) | $1,500 | $2,250 |
| Amount Payable By the Plan | 80% of the Allowed Amount | 60% of the Allowed Amount |
| Individual Out-of-Pocket Calendar Year Maximum | $2,500 | $5,000 |
| Family Out-of-Pocket Calendar Year Maximum | $5,000 | $10,000 |

**Note:** Out-of-Pocket maximums include the CYD amount, any applicable Copayments and Coinsurance amounts. Any non-covered charges or charges in excess of the Allowed Amount are not included. Prescription Drug Copayments, Deductible and/or Coinsurance amounts are not included.

The In-Network CYD and Out-of-Pocket Maximums and Out-of-Network CYD and Out-of-Pocket Maximums are separate, and as such, accumulate separately. Therefore, amounts incurred for In-Network shall be applied only to the In-Network CYD and Out-of-Pocket Maximums and Out-of-Network amounts incurred shall be applied only to Out-of-Network CYD and Out-of-Pocket Maximums.

**B. Office Services**

| Benefit Description | In-Network | Out-of-Network |
|---|---|---|
| Office Services Rendered by Family Physicians<br><br>A Family Physicians is a Physician whose primary specialty is, according to BCBSF's records, one of the following: Family Practice, General Practice, Internal Medicine, and Pediatrics. | $20<br>Copayment per visit* | 60%<br>of the Allowed Amount after CYD |
| Office Services Rendered by:<br>1. Physicians other than Family Physicians; and<br>2. Other health care professionals licensed to perform such Services. | $40<br>Copayment per visit* | 60%<br>of the Allowed Amount after CYD |
| Allergy Injections rendered by: | | |
| 1. Family Physicians | $10<br>Copayment per visit* | 60%<br>of the Allowed Amount after CYD |
| 2. Physicians other than Family Physicians and other health care professionals licensed to perform such Services. | $10<br>Copayment per visit* | 60%<br>of the Allowed Amount after CYD |
| Advanced Imaging Services: CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology rendered by: | | |
| 1. Family Physicians | $150<br>Copayment per visit* | 60%<br>of the Allowed Amount after CYD |
| 2. Physicians other than Family Physicians and other health care professionals licensed to perform such Services. | $150<br>Copayment per visit* | 60%<br>of the Allowed Amount after CYD |
| E-visit | | |
| 1. Family Physicians | $10<br>Copayment per visit* | 60%<br>of the Allowed Amount after CYD |
| 2. Physicians other than Family Physicians and other health care professionals licensed to perform such Services. | $10<br>Copayment per visit* | 60%<br>of the Allowed Amount after CYD |

| Benefit Description | In-Network | Out-of-Network |
|---|---|---|
| Durable Medical Equipment, Prosthetics, and Orthotics | 80%<br>of the Allowed Amount after CYD | 60%<br>of the Allowed Amount after CYD |

*These Services are subject to the Copayment only.

**Note:** You should verify a Provider's participation status whenever possible prior to receiving Health Care Services. To verify a Provider's specialty or participation status, you may contact the local BCBSF office, review the most recent Provider Directory or access the BlueOptions Provider directory at our web-site at www.bcbsfl.com.

**C. Outpatient Facility Services** (Locations other than Hospital, Psychiatric Facility, Substance Abuse Facility or Physician's Office)

| Benefit Description | In-Network | Out-of-Network |
|---|---|---|
| Ambulatory Surgical Center Services | $100<br>Copayment per visit* | 60%<br>of the Allowed Amount after CYD |
| Physician Services rendered at an Ambulatory Surgical Center by:<br>1. Radiologists, Anesthesiologists, and Pathologists;<br>2. all other Providers. | 80%<br>of the Allowed Amount after CYD<br>80%<br>of the Allowed Amount after CYD | 80%<br>of the Allowed Amount after CYD<br>60%<br>of the Allowed Amount after CYD |
| Independent Diagnostic Testing Facility Services<br>1. Advanced Imaging Services: CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology;<br>2. All other diagnostic Services | $150<br>Copayment per visit*<br>$50<br>Copayment per visit* | 60%<br>of the Allowed Amount after CYD<br>60%<br>of the Allowed Amount after CYD |
| Urgent Care Center | $45<br>Copayment per visit* | 60%<br>of the Allowed Amount after CYD |
| Independent Clinical Lab Services | 100%<br>of the Allowed Amount | 60%<br>of the Allowed Amount after CYD |

*These Services are subject to the Copayment only.

**D. Inpatient/Outpatient Services** (Rendered at a Hospital, Psychiatric Facility, or Substance Abuse Facility)

| **Benefit Description** | **In-Network** | | **Out-of Network** |
|---|---|---|---|
| | **Option 1** | **Option 2 and Out of State BlueCard® Participating** | |
| Inpatient Facility Services<br>(Applies per admission) | $600<br>Copayment* | $1,000<br>Copayment* | 60%<br>of the Allowed Amount<br>after CYD |
| Outpatient Facility Services<br>1. Therapy Services | $45<br>Copayment* | $60<br>Copayment* | 60%<br>of the Allowed Amount<br>after CYD |
| 2. All Other Services<br>(Applies per visit) | $200<br>Copayment* | $300<br>Copayment* | 60%<br>of the Allowed Amount<br>after CYD |
| Inpatient/outpatient Physician and other health care professional Services | 80%<br>of the Allowed Amount<br>after CYD | | 80%<br>of the Allowed Amount<br>after CYD |
| Emergency Room Facility Services<br>(Applies per visit)<br>Copayment waived if admitted | $100<br>Copayment* | | $200<br>Copayment* |

*These Services are subject to the Copayment only.

**Note:** Please refer to your Provider Directory to determine the applicable option for each In-Network Hospital.

## E. Preventive Health Services

| Benefit Description | In-Network | Out-of-Network |
|---|---|---|
| Preventive Adult Wellness Services rendered by: | | |
| 1. Family Physicians | $20 Copayment per visit* | 60% of the Allowed Amount |
| 2. Physicians other than Family Physicians; and Other health care professionals licensed to perform such Services. | $40 Copayment per visit* | 60% of the Allowed Amount |
| Preventive Adult Well Woman Services rendered by: | | |
| 1. Family Physicians | $20 Copayment per visit* | 60% of the Allowed Amount |
| 2. Physicians other than Family Physicians; and Other health care professionals licensed to perform such Services. | $40 Copayment per visit* | 60% of the Allowed Amount |
| Preventive Child Health Supervision Services rendered by; | | |
| 1. Family Physicians | $20 Copayment per visit* | 60% of the Allowed Amount |
| 2. Physicians other than Family Physicians; and Other health care professionals licensed to perform such Services. | $40 Copayment per visit* | 60% of the Allowed Amount |
| Routine Mammograms for Ages 40+ | 100% of the Allowed Amount | 100% of the Allowed Amount |
| Routine Colonoscopies for Ages 50+ | 100% of the Allowed Amount | 100% of the Allowed Amount |

*These Services are subject to the Copayment only.

## F. Benefit Maximums

**Ambulance** (Payable at the In-Network Coinsurance percentage) In addition to your share of the Coinsurance, you are responsible for the CYD and any additional amounts that exceed the per day maximum.

Per Person Per Day Maximum for ground, air and water travel..... $5,000

**Autism Spectrum Disorder Services**

Per Person Per Calendar Year.....$36,000
Per Person Per Lifetime.....$200,000

**Exception for Per Person Per Day Maximum:** Covered expenses for Ambulance Services for a newborn child, as described in the Newborn Assessment provision of the "What Is Covered?" section of the Booklet, are limited to a maximum of $1,000 per day.

**Enteral Formulas** Per Person Per Calendar Year ..... $2,500

**Home Health Care** Per Person Per Calendar Year..... $2,500

**Inpatient Rehabilitation** Days Per Person Per Calendar Year ..... 21

**Mental Health Services** (Inpatient) – Inpatient days/visits or combination of inpatient and Partial Hospitalization days, Per Person Per Calendar Year..... 30

**Mental Health Services** (Outpatient) – Outpatient Visits Per Person Per Calendar Year..... 20

**Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations** Per Person per Calendar Year..... $5,000
**Note**: Refer to the Benefit Booklet for reimbursement guidelines.

**Preventive Adult Wellness**

Rendered by an In-Network Provider- Per Person Per Calendar Year..... Unlimited
Rendered by an Out-of-Network Provider- Per Person Per Calendar Year..... $150

**Preventive Adult Wellness Services include**:

For purposes of this benefit an adult is 17 years or older.

1. annual physical or gynecological exam, including family planning/contraceptive Services; and
2. related wellness Services including, but not limited to, pap smears, Prostate Specific Antigen (PSA), x-rays, laboratory Services, and immunizations. Routine vision and hearing examinations and screenings are <u>not</u> covered.

**Note:** The wellness Services above are not subject to the CYD. Your share of the expenses may vary based on the location of service and whether the Provider is In-Network or Out-of-Network.

**Skilled Nursing Facility** Days Per Person Per Calendar Year ..... 60

**Substance Dependency Care and Treatment** – Inpatient, outpatient or any combination
Per Person Per Lifetime ..... $2,500

**Total Lifetime Maximum Benefit Per Person** ..... $5,000,000

## G. Additional Benefits/Features

### Accident Care

Covered Services in connection with an Accident are not subject to the Individual CYD. All other financial responsibilities, including the Copayment and Coinsurance requirements, will continue to apply.

### Benefit Maximum Carryover

If, immediately before the Effective Date of the Group, you or your Covered Dependent were covered under a prior group policy form issued by BCBSF to the Group, amounts applied to your Calendar Year benefit maximums and lifetime maximums under the prior BCBSF policy, will be applied toward your Calendar Year benefit maximums and lifetime maximums under the Benefit Booklet.

### Prescription Drug Program

The Group purchased optional pharmacy coverage from BCBSF. Please refer to the pharmacy program endorsement issued to the Group.

### In-Network Providers

NetworkBlue is the panel of NetworkBlue Providers designated as In-Network for your plan. Refer to your BlueOptions Provider directory for a complete listing of your In-Network Providers. If you receive Covered Services outside the state of Florida from BlueCard® participating Providers, payment will be made based on In-Network benefits.

**Note:** Please note that certain categories of Providers may not be available In-Network in all geographic regions. This includes, but is not limited to, anesthesiologists, radiologists, pathologists and emergency room physicians. We will pay for Covered Services rendered by any Physician in a Hospital setting (i.e., inpatient, outpatient, or emergency room) at the In-Network benefit level. If such Covered Services were rendered by a Physician who is not In-Network, you will be responsible for the difference between what we pay and the Physician's charge if the Physician is not participating in our Traditional Program. Claims paid in accordance with this Note will be applied to the In-Network Calendar Year Deductibles and In-Network Out-of-Pocket Calendar Year Maximums.